Annual Report 2004 - 2005

Success and challenge

NHS

UK Transplant

The launch of the 10th anniversary of the NHS Organ Donor Register at Trafalgar Square in October 2004 marked the start of a year-long public awareness campaign.

Our aim is to add one million more names to the register in the anniversary year.

(Front cover photo and right)

UK Transplant (UKT) is the special health authority responsible for all aspects of the donation, matching and allocation of solid organs and corneas for transplantation across all countries in the United Kingdom.

UKT's specific responsibilities include:

- leading the UK's organ donation and transplantation services
- increasing the availability of organs for transplant
- maintaining the national transplant lists
- matching, allocating and arranging the delivery of organs 24-hours, 365 days a year
- ensuring equity in access to, and allocation of, donor organs
- collecting, validating and maintaining an up-to-date clinical record of all donors and all transplant recipients to ensure patient safety and to monitor outcomes
- collecting information on every death in every intensive care unit to ascertain the potential donor pool
- raising awareness with the public and NHS staff about the importance of organ donation and encouraging people to consider donation and register their intentions
- managing the NHS Organ Donor Register so as to provide an up-to-date record for specified NHS staff of those willing to donate 24-hours, 365 days a year
- leading the solid organ donor co-ordinators across the UK
- managing the donation of corneas including the retrieval of eyes
- funding and supporting the UK's two biggest eye banks that supply corneas for transplantation
- leading public campaigns on organ donation and transplantation.

Chairman and Chief Executive's review

The decline in organ donation and transplantation that characterised the end of the 20th century has been reversed.

In the four years since the Department of Health approved our ambitious and innovative programme of reform and modernisation, UK Transplant has made considerable progress, achieving steady, underlying growth in the number of patients benefiting from a life-saving or life-enhancing transplant.

A major contributory factor has been the success of our pilot organ donation programmes which a formal impact assessment undertaken this year proved to be highly successful and cost-effective.

These non-heartbeating, living kidney donation and donor liaison and transplant co-ordination programmes are enabling more patients – particularly those with kidney disease or failure – to receive the gift of a donated organ.

Organ donation leaflets specially aimed at black people have been distributed through community centres, cafés, hair salons and local businesses.

The first quarter of 2005-06 saw 9% more organ transplants compared with the same period in 2004-05 and a 16% increase over the same quarter in 2003-04 – a year when we recorded the highest ever number of transplants.

The news is even better for kidney patients. A total of 502 patients received a new kidney between 1 April and 30 June 2005 compared with 440 during the same quarter in 2004 – a 12% increase – and 417 in the same period during 2003 – an increase of 18%.

During the year under review (2004-05) a total of 1,783 patients received a kidney transplant of which 475 (27%) were from a live donor – the highest number of living kidney transplants ever recorded in the UK. The living donor programmes alone have generated a 40% increase in living kidney transplants over the last four years.

The figures also include a record number of kidney transplants from non-heartbeating donors – 143, an impressive 20% increase on the previous year.

These results show the importance of developing new programmes and the real value of extending such programmes across all suitable NHS trusts.

In addition to these successes 2,375 people had their sight restored by a cornea transplant – the highest number for eight years.

A further 86 people received a pancreas or combined kidney/pancreas transplant – again the highest number on record.

We are now in the fourth year of our five year programme of reform and modernisation. UK Transplant is now fully established and highly regarded by all of its stakeholders as an effective NHS organisation. The support of our stakeholders ensures we continue to make a significant impact on the quantity and quality of solid organ and cornea transplantation services.

Our organ donation programmes are excellent examples of effective use of NHS resources – saving the NHS ten times the amount that is invested in them. The Department of Health has

Nurses at Southmead Hospital in Bristol helping to raise awareness of the NHS Organ Donor Register.

Ambitious and innovative

recognised the value of these programmes by agreeing to maintain funding to ensure successful programmes remain in place until 2008. This offers assurance to both clinicians and patients that activity rates should be both maintained and improved in the next three years.

Patients are experiencing real benefits. Transplant success rates have improved with 85% of heart transplants, 87% of liver transplants, 93% of living kidney grafts and 88% of transplants using kidneys donated after death surviving the critical first year.

The safety and effectiveness of transplantation are key watchwords in all our operations and we place considerable reliance on our expert advisory groups, who make a major contribution to defining the rules and processes that underpin our success. These groups, drawn from leading transplant clinicians and patient representatives, are supported by our world-class statistical and audit team.

UK Transplant is charged with the responsibility for maintaining equity of access to transplantation. During the year changes were made to the heart/lung allocation procedures to improve equity of access. In addition the Kidney and Pancreas Advisory Group undertook a root and branch review of the kidney allocation scheme and has proposed a new approach that will achieve more equitable waiting times for patients on the transplant list. A similar review is planned for the allocation of livers.

UK Transplant has led the world and created a precedent for others to follow by undertaking a comprehensive audit of potential donors. We have now audited in excess of 40,000 deaths. This has provided crucial evidence identifying where donors are lost and provided detailed evidence on how the donor pool could be expanded to benefit yet more patients.

We now know, for example, that 40% of relatives say "no" to organ donation, mainly because they don't know what their loved one would have wanted or have never talked about organ donation. We are addressing this by training all front line staff, including donor transplant co-ordinators, who approach bereaved families.

Karen Draper (left), a tissue donor co-ordinator, with cornea recipient Tracey Foster. Two cornea transplants have given Tracey back her sight and the joy of seeing the faces of her three young children again.

Our communications team is committed to improving public awareness and support for organ donation.

During the year we celebrated the launch of the 10th anniversary of the NHS Organ Donor Register (ODR) with a series of high profile activities and events. Our success in promoting organ donation, in conjunction with charities and other partners, has encouraged a further one million people to add their names to the ODR during 2004-05, bringing the total number of registrants to 12.1million.

In our continual pursuit of best practice UK Transplant became a partner in two major projects funded by the European Commission to review aspects of organ donation and transplantation across Europe. This sharing of knowledge and best practice helps to raise standards internationally.

During the year we received notice that, as a result of the Department of Health Arm's Length Body review, UK Transplant will be abolished on 30 September 2005 and its functions merged with those of the National

Taking the organ donation message into Asian communities at a summer festival.

Fully established and highly regarded

Blood Authority. A new organisation, NHS Blood and Transplant, will be established on 1 October 2005.

This has created significant uncertainty for the organisation, its staff and stakeholders. To the credit of all involved there has been a very focused approach to ensure "business as usual" and to safeguard standards and improve performance. That this is being achieved despite the huge additional amount of work for staff is a credit to all.

The strategic horizon has changed as a consequence of the real improvements in the transplantation service that we have delivered during this and the last four years. We now have compelling evidence about what works and what doesn't and the barriers to increasing donation rates.

The challenge for the new NHS Blood and Transplant is to ensure a continued focus on transplantation, continued commitment to appropriate investment and a continued emphasis on the importance of partnership working. The acceptance of this challenge, coupled with the continuing hard work and loyalty of the dedicated staff of UK Transplant, offers the promise that patients will continue to see ongoing improvements in NHS transplant services.

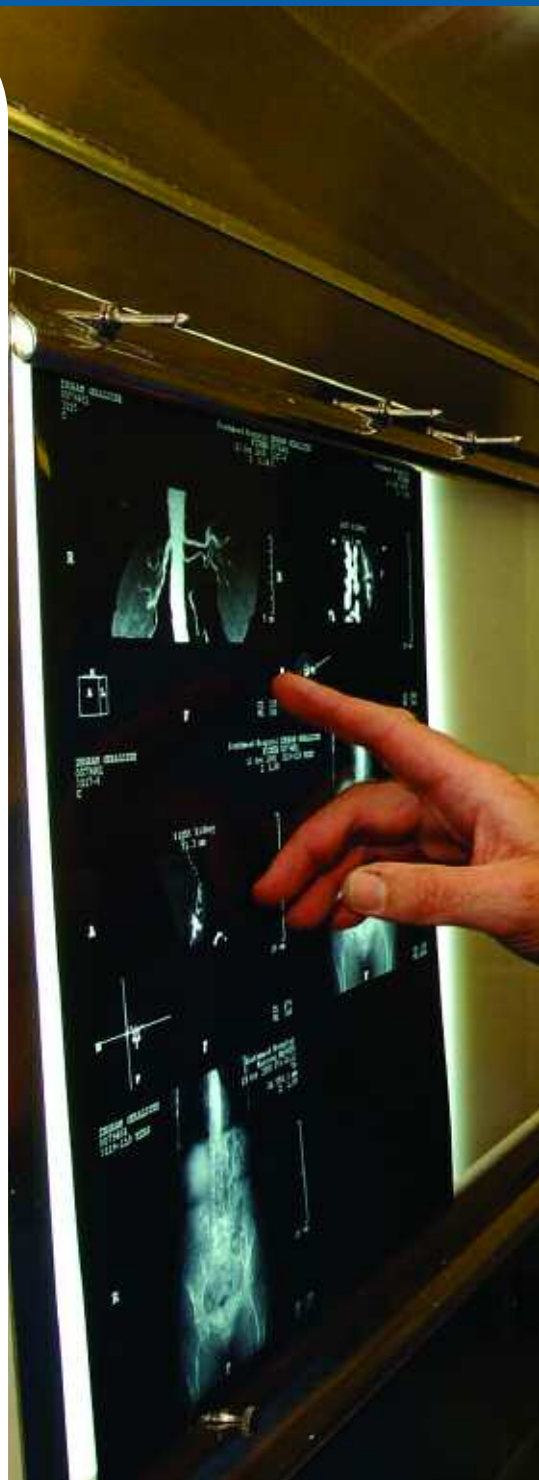
Top left
Our potential donor audit, being carried out in intensive care units all over the country, will help us find ways to increase the number of donors.

Top right
Our Patients' Forum ensures that UKT hears the patients' perspective on a range of issues.

Bottom
Our communications team takes a pro-active approach in raising awareness of organ donation.

Gwynneth Flower - Chairman

Sue Sutherland - Chief Executive



Successful and cost-effective

Better surgical procedures have contributed to better transplant success rates, with survival beyond the critical first year improving all the time.

New challenges for 2005-2006

One of UK Transplant's key objectives is to ensure a smooth transition into the newly formed NHS Blood and Transplant and, at the same time, keep on improving access to transplantation.

Once the new authority is formed we will begin work on a corporate plan setting out the goals for transplantation for the next five years (2006-2011). We will need to ensure business continuity and that the number and safety of transplants is not jeopardised by required Arm's Length Body review savings targets.

Organ donation

In 2005-06 we aim to increase the number of people who benefit from an organ or ocular tissue transplant to 5,433, a further 2% by:

- continuing to fund and performance manage 13 non-heartbeating, 25 live donor programmes and re-invest donor liaison funding into alternative schemes
- making a 12% reduction in the percentage of relatives refusing consent, from 42% to 37% overall
- working with colleagues to introduce a collaborative model of approach to families of potential donors in 50% of acute trusts and to deliver training on this approach to critical care clinicians
- continuing work on the Potential Donor Audit (PDA) – collecting further data and investigating some of the issues coming to light such as the reasons relatives refuse consent for donation.

Equity

We will improve equity of access to donor organs for all patients by:

- publishing new kidney allocation rules that have been widely consulted on and putting the new allocation scheme in place
- reviewing revised zonal arrangements for liver and pancreas transplantation and equity of access to liver transplantation
- conducting research into attitudes towards organ donation and awareness of the NHS Organ Donor Register within the South Asian and black communities with a view to increasing the numbers of donors from these communities.

Last year a record number of living kidney transplants was achieved. This patient gave a kidney to her nephew through one of the living kidney programmes funded by UKT.

Clinical governance

We will maintain robust clinical governance arrangements by:

- continuing to review transplant outcomes in terms of the number of transplants and survival rates from specific transplant centres
- performance managing the distribution of corneal tissue to NHS trusts from eye banks.

NHS Organ Donor Register (ODR)

We will increase the number of people registered on the ODR from 12.1 to 13 million by:

- continuing to raise awareness of the ODR through our series of 10th anniversary events
- developing further partnerships with local authorities, health administrations, the media and charitable and commercial organisations to create more opportunities for people to register their wishes.

Debbie Greensill, a donor liaison nurse in Staffordshire, teamed up with local cricket players to raise awareness of the register.

Committed to equitable allocation

Transplantation milestones

In December 2004 the world celebrated the 50th anniversary of the first successful kidney transplant and in December 2005 we will be celebrating the 100th anniversary of the first successful cornea transplant.

Here, members of the transplant community reflect on the major achievements in transplantation in the UK and look forward to the challenges that face us in the future.

David Mayer, Consultant Surgeon in the Liver Transplant Unit at Queen Elizabeth Hospital, Birmingham and the Birmingham Children's Hospital, and chairman of UKT's Liver Advisory Group.

Outcomes of early liver transplants in the 1970s were very poor. Out of the first 80 patients only 13 survived the year. Now in the UK we do nearly 700 a year and the vast majority go on to lead a healthy life.

This is because we have better patient assessment and preparation, we have refined surgical procedures, we have a better understanding of the physiology, the anaesthesia and intensive care management of patients afterwards, and we have better immunosuppression.

We have better patient assessment, better surgical procedures, better intensive care management and better immunosuppression.

UKT plays a vital role in the rigorous and independent audit that is carried out to monitor the performance of the organ allocation schemes. The collection and analysis of data from organ retrieval centres enables us to measure progress and ensure that high standards are maintained.

The co-operation of the retrieval units in the UK is unique. However, despite all our efforts, the number of people needing a liver transplant is rising significantly and patients are dying because they can't get a liver in time. I hope in the future we can cure some of the diseases which lead to the need for transplants.

Although there are now effective treatments for some patients with hepatitis C, many still develop cirrhosis and liver cancer, and the demand for liver transplants for hepatitis C will continue to rise for the foreseeable future.

There is also a real concern about young people and alcohol abuse and we are likely to see more patients coming forward with liver damage as a result.

One area where we could make a difference is in living donation. I expect to see the development of live donor liver transplantation in several UK centres in the next few years. There are concerns about the risk to the donor but this has to be balanced against the increasing number of deaths on the liver transplant list.

Professor John Wallwork, Director of the Transplant Service, Papworth Hospital NHS Foundation Trust, and chairman of UKT's Cardiothoracic Advisory Group.

UKT's focus on donor care and management has enabled us to maximise the number and quality of organs.

Transplantation has come a very long way since we started the heart transplant programme at Papworth Hospital more than 25 years ago.

In those early days patients were nursed in isolation for three or four weeks after their transplant and stayed in hospital for several months afterwards. Most patients are now able to leave hospital after just a couple of weeks.

This progress has been achieved with better drugs and a better understanding of how to monitor patients.

These days heart transplantation is an established way of treating people with severe heart failure, giving them an excellent quality of life. Many people who have had heart transplants are now living 15 or 20 years, well into their retirement.

In the last two years we have seen a slight upturn in cardiothoracic activity and we must try to sustain this. It is only through national initiatives and a nationally organised programme that we have been able to achieve this. For instance, UKT's focus on donor care and management has meant that we have been able to maximise the number and quality of organs available for transplant.

The biggest handicap is that we just don't get access to enough donor organs to be able to help all the people who need them.

In future, although heart transplantation will still play a part in treating people with heart failure, we could see the use of various devices, such as mechanical hearts, perhaps the use of stem cells and, possibly, the use of animal organs for transplantation, but all these developments are still some time in the future.

Our biggest challenge with transplantation is the treatment of chronic rejection. We need to develop better ways of manipulating the immune system to prevent this and so further prolong the survival of transplant patients.

It is impossible to say when that day will come – but considering how far we have come in the last 25 years, who knows?

Fiona Wellington, a former donor transplant co-ordinator, has been Donor Transplant Co-ordinator Regional Manager for the Midlands, Trent and Anglia for the past three years.

Our team of five regional managers provides central support and professional leadership to the 21 teams of donor transplant co-ordinators (DTC), the donor liaison nurses and eye retrieval staff across the UK – to maximise the quantity and quality of organs and tissue donated.

A number of significant changes have taken place over the last three years.

These include the appointment of team leaders for 85% of DTC teams, the provision of one whole-time equivalent co-ordinator per million population, and the implementation of national job descriptions along with nationally agreed standards of practice and competencies.

UK Transplant doesn't employ co-ordinators, although we fund 26 of the 106 whole-time equivalent posts, so we have to manage by influence, working closely with the trusts and co-ordinators.

We manage by influence, working closely with trusts and co-ordinators.

There are never enough donors because waiting lists are increasing all the time – and this is clearly the biggest challenge we face.

A major achievement has been the implementation of the Potential Donor Audit within all intensive care units in the UK. For the first time, this provides us with accurate data on the true potential for organ donation, and has highlighted family refusal to give consent as the biggest obstacle we have to overcome.

As a result, this year we will be working with the DTC teams and intensive care staff to encourage a collaborative model of approaching potential donor families and investigating the option of appointing in-house co-ordinators in units identified as having the greatest donation potential.

In addition, with the establishment of NHS Blood and Transplant, we will be working together with the tissue donor co-ordinators to establish a management model for the future for all those working in organ and tissue donor co-ordination.

John Forsythe, Transplant Centre Director, Royal Infirmary of Edinburgh Renal Transplant Unit and chairman of UKT's Kidney and Pancreas Advisory Group.

Kidney transplantation results have improved remarkably, almost year on year, over the last decade. Nowadays around 85-95% of transplanted kidneys are still working efficiently after one year. Those figures are fantastic compared to many of the major interventions which are carried out in large modern hospitals.

In the early years we were talking about success rates of 55-60% one-year transplant survival. The major problem was rejection in those days. Now we have very much better drugs to take on rejection and, in the vast majority of cases, beat it.

Transplantation has become a much more routine treatment for kidney failure and is accepted as being the best form of treatment for those patients for whom it is suitable.

The major problem that is still facing transplantation is the shortage of donor organs. That is why we have seen such a rise in the number of living donations.

Kidney transplantation results have improved remarkably over the last decade.

There are nearly 8,000 people in the UK needing a transplant. Those people face an uncertain wait for a kidney transplant and we know that living donor transplants are very, very successful both in the short and longer term.

Over the last few years UKT has made a significant contribution to attempting to overcome the donor shortage, primarily in living donor kidney transplantation, non-heartbeating donation and co-ordination programmes which have helped develop the profile of transplantation in the UK.

People have to take quite strong medication to avoid rejection and there are side effects associated with those drugs. It would be tremendous if we had the ability to transplant without the on-going need for these drugs. That is still some time away.

Cellular transplantation will be developed over the next few years; the most obvious is islet cell transplantation. These islets can be introduced into the liver and they can then produce insulin and control diabetes, which is one of the leading causes of renal failure in the UK.

Dr Susan Fuggle, Director of Clinical Transplant Immunology at the Oxford Transplant Centre, and UKT's scientific adviser.

The immunology of transplantation is an evolving field and has developed tremendously in recent years.

In the early days it was discovered that kidneys could be rejected immediately, on the operating table, because of pre-existing antibodies. This led to the introduction of immunological testing. At the time of transplantation, consideration is given both to the HLA match between the donor and recipient and whether there are antibodies that will cause that transplant to be rejected.

UKT's major evidence-based review of kidney allocation in the last year has shown that changes can be made to the kidney allocation scheme to really improve equity of access to renal transplantation whilst still achieving good HLA matching.

Another exciting development is the introduction of desensitisation programmes whereby it is possible to remove pre-existing antibodies that would be damaging to the transplant. The treatment creates a window in which the patient can be safely transplanted. This is a major advance and means we are able to treat patients who may otherwise be difficult to transplant.

There is a resurgence of interest in antibodies. There is no doubt that antibodies produced after transplantation contribute to the chronic loss of transplants. Reducing the production of these antibodies can improve the life of a transplant.

One of the long-term goals in transplantation research is to achieve a state of immunological tolerance in the recipient, such that the body does not mount an immune response to the transplant. If this could be achieved, it would mean reduced levels or even absence of immunosuppressive medication that can be detrimental in the long term. This is the holy grail of transplantation.

The immunology of transplantation is an evolving field and has developed tremendously in recent years.

Peter McDonnell, consultant ophthalmic surgeon at the Birmingham and Midland Eye Centre and chairman of UKT's Ocular Tissue Advisory Group (OTAG).

One of the great advantages of corneal transplantation is that once the eye is retrieved it can be stored for up to 30 days before it needs to be used.

Eye banks, in Manchester and Bristol, have made the organisation of corneal transplants in the UK so much easier because a patient can be booked in and the cornea will be available for that operation.

In the last two years UKT, with OTAG, has carried out a major review of the eye retrieval service. Up until now eye retrieval around the country was on an ad-hoc local basis.

Now, with funding organised by UKT, we are setting up a national scheme with eight specialist eye retrieval centres around the country. Things look very encouraging and we are set to significantly increase both the number and quality of corneas retrieved nationally.

We are set to significantly increase both the number and quality of corneas retrieved nationally.

Staff at these centres will be specially trained in the techniques of eye retrieval which means there will be less chance of the cornea not being suitable for use.

They will also have a role in talking to relatives and staff about the importance of eye, tissue and organ donation, so hopefully we can increase donor numbers.

The other area that is really developing is limbal stem cell transplantation. These are stem cells at the edge of the cornea which supply the healthy new cells that cover the surface of the cornea. If they are damaged in some way, perhaps by a chemical burn or certain auto-immune conditions, the surface never heals properly and the sight can be lost.

There are new techniques being developed where small numbers of stem cells are removed from the patient's healthy eye, grown in the laboratory and then used to treat the damaged eye.

Similar techniques could be used to take limbal stem cells to provide a source of healthy new cells to cover the cornea. This would lead to improved sight for many more patients.

Carol-Ann Brown, mother of twins, aged 35, who lives in North Lanarkshire, Scotland, had a liver transplant nine years ago.

My transplant gave me back my life – and the chance to have a family.

Before the transplant I wasn't able to have children because of all the drugs I had been taking since I was a child.

But after the transplant, I became pregnant and had my two lovely children Hope and Ryan, who are now six.

When I found I was pregnant I just cried. I don't think I really believed it until they actually came. I wouldn't have been here without the liver and the twins wouldn't be here either.

My mother calls them "little miracles" and that is just what they are. Sometimes when they are driving me up the wall, I stop and think how lucky I am to have them.

I was diagnosed with cirrhosis of the liver when I was 11. I never gave it much thought at that age. I just took the tablets and got on with my life.

My teenage years were pretty normal really. I went to discos, went abroad with the school and with my friends and had a part-time job while I was at college and when I was 23 I got married to my husband Daryl.

At about that time I began feeling really tired and two years later I was advised to stop work – and was put on the transplant waiting list.

Eight weeks after being placed on the active waiting list I was told a liver was available, and I had my transplant in the Royal Infirmary of Edinburgh in November 1996.

I can remember getting the call. You're never ready for it. But within three months I was feeling great. I wasn't tired anymore.

I couldn't believe what it was like to feel so awake. That was the biggest shock to the system. Before the transplant I had been sleeping for 12 hours every night, and napping through the day.

I can never thank the family enough who agreed to donation and I look forward to the day when everyone who needs a transplant can have one.

I can never thank the family enough who agreed to donation.

Special Health Authority Board

UK Transplant is governed by a board that consists of a chairman, chief executive, six executive (three voting) and seven non-executive directors.

Gwynneth Flower

Sue Sutherland

Chairman

Gwynneth Flower *(1)* was appointed in April 2001. She is also chairman of the National Meteorological Programme Commissioning Board. She was a director of CMB group and CMB Technologies until March 2003. She is also a director of 2change Ltd specialising in managing business change. In 1991 she set up CENTEC, the largest of the country's Training and Enterprise Councils. She was also managing director of Action 2000, which was responsible to the Prime Minister for ensuring that the UK economy did not suffer material disruption from the "Millennium bug".

Chief Executive

Sue Sutherland joined UK Transplant in September 2000. Her career has spanned 34 years both in the NHS and a major health charity. She worked as a nurse and midwife in London, Cheshire and Surrey, then embarked on a career in NHS management. Sue has held a number of executive director posts in the acute sector including Director of Operations and Nursing at the Royal Devon and Exeter Healthcare NHS Trust.

Executive members

Chris Rudge, Medical Director, joined UK Transplant in 2001 to provide clinical leadership. He continues to spend one day a week at the Royal London Hospital where he was a consultant renal transplant surgeon. He initiated the development of the first local renal transplant alliance in 1996.

Martin Davis, part-time Finance Director, joined UK Transplant in November 2001. He has worked in the NHS since 1974 at director of finance level in all tiers of the health service within Gloucestershire and the south west region.

Sue Falvey, Director of Donor Care and Co-ordination, joined UK Transplant in 1997 as duty office manager and was appointed to her current role in January 2002. Sue is a nurse who spent 20 years working in organ transplantation at St Mary's Hospital in London and Addenbrooke's and Papworth hospitals in Cambridgeshire.

David Shute, Director of Information, Technology and Support Services, joined UK Transplant in 1998. He is a qualified accountant with management experience in both the private and public sector.

Penny Hallett, Director of Communication and Public Relations, is a former journalist with 21 years' experience of public relations and marketing. She joined UK Transplant in September 2001 from Avon and Somerset Constabulary, where she was Head of Communication.

Dave Collett, Director of Statistics and Audit, joined UKT in August 2003. Before this he was a senior lecturer in applied statistics at the University of Reading, and was Head of Department for eight years. He is the author of text books on the analysis of survival data and modelling binary data.

Key

(1) Member of Remuneration and Terms of Service Committee

(2) Member of Audit Committee

The chairman and the non-executive directors were appointed by the Health Minister through open competition. The chief executive was appointed through open competition. The executive directors were appointed following open competition by a board comprising a minimum of the chief executive and one non-executive director. All appointments are subject to the terms and conditions of NHS senior managers.

Key (photo)

1 Margaret Branthwaite
2 Sue Falvey
3 Sue Sutherland
4 Gurch Randhawa
5 Penny Hallett
6 Martin Davis
7 Alastair MacGilchrist
8 George Jenkins
9 David Shute
10 Dave Collett
11 Judith Mackay
12 Gilbert Park
13 Chris Rudge
14 Gwynneth Flower

Neil Goodwin not pictured

Non-executive members

Margaret Branthwaite *(2)* was a consultant anaesthetist and physician at the Royal Brompton Hospital. In 1991 she retrained as a barrister and has also worked as an assistant deputy coroner and for the Medical Defence Union. She is author of *Law for Doctors: principles and practicalities* and is now retired.

Dr Neil Goodwin *(1)* is chief executive of the Greater Manchester Strategic Health Authority. He has operated at chief executive level for 21 years including six years at St Mary's Hospital NHS Trust in London. Neil has also participated in a cabinet office review of public sector leadership development.

George Jenkins *(2)* has served as managing director and chairman on a number of company boards. A Fellow of the Institute of Directors, he has experience of mergers and acquisitions, change management, recovery situation and corporate governance. He is currently chairman of East Kent Hospitals NHS Trust.

Alastair MacGilchrist *(2)* has been a consultant transplant hepatologist in the Liver Transplant Unit at the Royal Infirmary of Edinburgh since 1992. The unit has successfully developed liver transplantation in Scotland.

Judith Mackay *(2)* is head of Aston Media at Aston University and has worked in the commercial sector, particularly the communications industry. She was former chair of the Northern Birmingham NHS Mental Health Trust and is a non-executive director of the Birmingham Women's Health Care NHS Trust.

Dr Gilbert Park *(1)* is Director of Intensive Care Research and Consultant in Anaesthesia at Addenbrooke's Hospital in Cambridge. He has been involved with organ transplantation as a consultant and author for over 20 years and is Secretary General of the World Federation of Societies of Intensive and Critical Care Medicine.

Gurch Randhawa *(1)* is a principal research fellow in the Institute of Health Services Research at the University of Luton with a specialist interest in diabetes care and renal transplantation among South Asians. He is an advisory member for the National Kidney Research Fund and chair of Luton Primary Care Trust.

Directors' remuneration and salaries		2004 - 2005		2003 - 2004	
		Salary (£5k bands)	Benefits in kind (£00)	Salary (£5k bands)	Benefits in kind (£00)
Executive	David Collett - Director of Statistics & Audit	50 - 55	0	35 - 40	0
	Martin Davis - Director of Finance	35 - 40	0	35 - 40	0
	Sue Falvey - Director of Donor Care	45 - 50	0	45 - 50	0
	Penny Hallett - Director of Communication	50 - 55	0	50 - 55	0
	David Shute - Director of I, T & SS	55 - 60	0	55 - 60	0
	Sue Sutherland - Chief Executive	90 - 95	*8	90 - 95	*8
	Chris Rudge - Medical Director	100 - 105	0	95 - 100	0
Non-executive	Gwynneth Flower - Chairman	15 - 20	0	15 - 20	0
	Margaret Branthwaite	5 - 10	0	5 - 10	0
	Neil Goodwin	5 - 10	0	5 - 10	0
	George Jenkins	5 - 10	0	5 - 10	0
	Judith Mackay	5 - 10	0	5 - 10	0
	Alastair MacGilchrist	5 - 10	0	5 - 10	0
	Gilbert Park	5 - 10	0	5 - 10	0
	Gurch Randhawa	5 - 10	0	5 - 10	0

Pension benefits	Real Increase in pension and related lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2005 and related lump sum (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2005 (£000)	Cash Equivalent Transfer Value at 31 March 2004 (£000)	Real increase in Cash Equivalent Transfer Value (£000)
David Collett - Director of Statistics & Audit	50 - 52.5	140 - 145	574	348	**217
Martin Davis - Director of Finance					***
Sue Falvey - Director of Donor Care	2.5 - 5	55 - 60	185	166	14
Penny Hallett - Director of Communication	75 - 77.5	130 - 135	524	202	**317
David Shute - Director of I, T & SS	2.5 - 5	80 - 85	318	288	21
Sue Sutherland - Chief Executive	5 - 7.5	125 - 130	521	471	36
Chris Rudge - Medical Director	2.5 - 5	155 - 160	699	651	30

* Rounded up to the nearest £00
** Both employees transferred pensions in from previous employers during the year
*** This member of staff is non-pensionable

As non-executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for non-executive members. The one item of Benefits in Kind relates to £760 for Regular User Lump Sum (car)

Financial and Management Overview

The accounts of the Authority for the financial year 2004-2005 have been prepared in accordance with the Secretary of State's direction, with approval of HM Treasury.

The Authority remained within its Revenue and Capital resource limits, and the overall cash limit issued by the Department of Health.

In 2004-2005 a further £4.177m was invested in a range of organ donation initiatives in hospitals and transplant centres in the UK. The total amount invested in these initiatives since 2001-2002 is £9.959m.

At the year-end the Authority had retained cash balances of £1,166.00.

Overall reserves increased by £134,000 from £4.923m to £5.027m.

No expenditure was incurred on research and development during the year.

At 31 March 2005 the Authority's fixed asset structure (Net Book Value) is:

	£000
Land	1,300
Buildings	3,461
Assets under construction	65
Plant & machinery	52
Transport	7
Information technology	484
Furniture & fittings	8
	5,377

The Net Book Value of Land and Buildings reflect the opening value as at 1 April 2005 following the revaluation of NHS estate by the District Valuer.

A register is maintained to record any personal financial interests which directors or staff may have which might conflict with their responsibilities within UK Transplant. For 2004-2005 Martin Davis, Director of Finance declared an interest by providing freelance professional services to the Authority trading as Martin G Davis CPFA, FCCA.

The Authority's external auditor is the Comptroller and Auditor General. The cost of the audit for 2004-2005 was £37,000. No additional work was carried out beyond the scope of the statutory audit.

The revenue budget for 2005-2006 has been approved and funded at £13.572m. The capital budget has been set at £232,000. The budget includes additional funding made available for year 5 of the Authority's 5-year business case, as well as £400,000 savings in response to the initial savings targets resulting from the Arm's Length Body review.

Financial Year	Parliamentary Funding	Total Operating Income	Net Operating Cost
	£000	£000	£000
2004-2005	12,762	1,982	12,535
2003-2004	9,693	1,653	9,369
2002-2003	8,257	1,448	8,055
2001-2002	5,951	1,074	6,038
2000-2001	5,436	910	5,386

The Authority's final cash and resource limits for the year was:

	£000	£000
Revenue		
Core and Renal Promotion	10,586	
Organ Donor Register	116	
Campaigns	774	
Agenda For Change	63	
Cost of Capital (resource only)	569	
Permanent Injury Benefit (resource only)	454	12,562
Capital		200
Total		**12,762**

Summary financial statement

The figures set out below provide a summary of the detailed financial accounts of the Authority. The summary may not contain sufficient information for a full understanding of UKT's financial position. These are available from The Stationery Office, or free of charge from Colin Day, Head of Finance, UK Transplant, Fox Den Road, Stoke Gifford, Bristol BS34 8RR (tel 0117 975 7489). The summary financial statement has been prepared in a form consistent with the full financial statements.

Operating cost statement for the year ended 31 March 2005

	Notes	2004-05 £000	2003-04 £000
Programme expenditure	2.1	14,517	11,022
Operating income	4	(1,982)	(1,653)
Net operating cost before interest		12,535	9,369
Net operating cost		12,535	9,369
Net resource outturn	3.1	12,535	9,369
All income and expenditure is derived from continuing operations			

Statement of Recognised Gains and Losses for the year ended 31 March 2005

	2004-05 £000	2003-04 £000
Unrealised surplus/(deficit) on the revaluation of fixed assets	397	0
Unrealised surplus/(deficit) on the indexation of fixed assets	326	336
Recognised gains and losses for the financial year	**723**	**336**

Cash flow statement for the year ended 31 March 2005

	2004-05 £000	2003-04 £000
Net cash (outflow) from operating activities	(11,518)	(8,985)
Servicing of finance	0	0
Capital expenditure and financial investment:		
(Payments) to acquire tangible fixed assets	(254)	(209)
Net cash inflow/(outflow) from investing activities	**(254)**	**(209)**
Net cash (outflow) before financing	(11,772)	(9,194)
Financing		
Net Parliamentary funding	11,739	9,153
Health Departments Capital Funding	32	32
Increase/(decrease) in cash in the period	**(1)**	**(9)**

Balance sheet as at 31 March 2005

	Notes	31 March 2005 £000	31 March 2004 £000
Fixed assets:			
Tangible assets	5.1	5,377	4,745
		5,377	**4,745**
Current assets			
Stocks	6	0	0
Debtors	7	483	520
Cash at bank and in hand	8	1	2
		484	**522**
Creditors: amounts falling due within one year	9.1	(350)	(333)
Net current assets/(liabilities)		134	189
Total assets less current liabilities		**5,511**	**4,934**
Provisions for liabilities and charges	10	(454)	(11)
		5,057	**4,923**
Taxpayers' equity			
General Fund	12.1	3,312	3,862
Revaluation reserve	12.2	1,745	1,061
		5,057	**4,923**

Signed: Susan J Sutherland 23 August 2005
Accounting Officer

Statement of internal control 2004-2005

1. Scope of responsibility

As Accounting Officer I have responsibility, together with the Board of UK Transplant, for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accounting Officers' Memorandum issued by the Department of Health.

The Chief Executive meets with the Department of Health quarterly to discuss performance and risk. Key items of risk highlighted from internal performance monitoring meetings between the Executive Directors and each directorate are discussed with the DOH at these meetings. The risk register is on the agenda of each Audit Committee, which is then verbally reported to the SHA Board Meeting. An annual risk report is presented to the full SHA Board; the DOH routinely receives copies of all papers.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in UK Transplant for the year ended 31 March 2005 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

The Authority's Audit Committee review the risk register and action plan at each meeting. This is then reported verbally to the SHA. An annual risk report is presented to the full SHA Board. The responsibility for the leadership and day-to-day risk management has been delegated to the Director of Information, Technology and Support Services, and is therefore at a high level within the Authority.

Risk management has been explained to all staff at the Authority. Staff are required to report on new and existing risks at the quarterly performance monitoring meetings.

4. The risk and control framework

Directorates are encouraged to identify risks before new areas of work are started. Each risk is identified and scored using the standard model, which rates the risk in terms of likelihood and consequences. This is then entered on the risk register, and appropriate action identified to reduce that risk to an acceptable level.

This system is embedded in to the organisation through the quarterly performance review process, where directorates are prompted to review all new and existing areas of risk. The Audit Committee, through their review of the register, also actively monitor areas of risk and measures implemented to reduce them.

The Authority has an assurance framework in place, which identifies its key objectives, potential risks, and the procedures and controls in place to reduce those risks to acceptable levels. It also provides evidence to the Board that key objectives are being met.

5. Review of effectiveness

As Accounting Officer, I have responsibility, together with the Board, for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurances. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by routine internal and external audit reports, and the quarterly performance monitoring process operating within the Authority.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, Audit Committee, Information Security Group, and the Health and Safety Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

In summary the leadership and day-to-day management of the risk and

controls assurance framework are the responsibility of the Director of Information, Technology and Support Services. Directorates are encouraged to identify, monitor and manage risks as part of the quarterly performance review process. Senior managers complete the controls assurance questionnaires at least annually, and this work is reviewed by the SHA, Audit Committee, External and Internal Audit.

No significant control weaknesses have been identified.

Signed .....

Chief Executive Officer

27 June 2005

Better Payment Practice Code - measure of compliance

	Number	£000
Total bills paid 2004-05	2,124	4,696
Total bills paid within target	2,117	4,690
Percentage of bills paid within target	99.7%	99.9%

Comptroller and Auditor General's statement to the Houses of Parliament and the Scottish Parliament

I have examined the summary financial statement of UK Transplant set out on pages 22 to 24, which has been prepared in a form consistent with the full financial statements.

Respective responsibilities of the Chief Executive and Auditors

The summary financial statement is the responsibility of the Chief Executive as Accounting Officer.

My responsibility is to report to you my opinion on its preparation and consistency with the full financial statements and foreword. I also read the other information contained in the Annual Report and consider the implications for my report on the summary financial statement if I become aware of any apparent misstatements or material inconsistencies with the summary financial statement.

Basis of opinion

I conducted my audit having regard to Bulletin 1999/6 "The auditor's statement on the summary financial statement" issued by the Auditing Practices Board for use in the United Kingdom.

Opinion

In my opinion the summary financial statement on pages 22 to 24 is consistent with the full financial statements and foreword of UK Transplant for the year ended 31 March 2005 and has been properly prepared in a form consistent with the full financial statements.

Signed .....

Claire Rollo for Comptroller and Auditor General

31 August 2005

National Audit Office
157-197 Buckingham Palace Road
Victoria
London
SW1W 9SP

In 2004-05 UKT funded more than 80 programmes in NHS hospitals to increase the number of live and deceased donors. These were: 33 donor liaison schemes, 25 living kidney donor programmes, 13 non-heartbeating donation programmes and 11 transplant co-ordinators.

NHS

UK Transplant

Fox Den Road, Stoke Gifford, Bristol BS34 8RR
Tel: 0117 975 7575 Fax: 0117 975 7577
Email: enquiries@uktransplant.nhs.uk

Organ Donor Line: 0845 60 60 400
www.uktransplant.org.uk

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